ENCLOSURE 11

EMT Course Clinical Substitution Request

THIS FORM SHOULD BE USED WHEN ALL OTHER AVENUES HAVE BEEN EXHAUSTED TO ACQUIRE FIELD OR HOSPITAL CLINICAL EXPERIENCE FOR THE EMT CANDIDATES.

*A SEPARATE REQUEST MUST BE SUBMITTED FOR **EACH** COURSE.*

_____ _____

EMT TRAINING INSTITUTION DATE

_____

EMT PROGRAM COORDINATOR (**PRINT**)

COURSE NUMBER: _____ # OF STUDENTS: _____

I request permission for this EMT class to satisfy their clinical requirements with programmed patients in class.

I verify that I have contacted at least one (1) EMS service and at least one (1) hospital to secure clinical for these students and have been refused access.

I understand that the in-class, programmed patient clinical is **in addition to the scheduled 143 classroom hours**. I understand that each student is expected to have documentation of five (5) full patient assessments.

I HAVE ENCLOSED THE FOLLOWING REQUIRED DOCUMENTATION OF MY EFFORTS: A letter (to DHEC from the EMT Program Coordinator) indicating the following information:

- The name and title of the person(s) I contacted who refused to accept these students for clinical experience. (One must be the person in charge of a SC licensed ambulance provider - AND - one from an area hospital).

- Schedule of when the in-class clinical will take place if approved.

NOTE: This letter must be dated after the start date of the course.

_____ _____

SIGNATURE: EMT PROGRAM COORDINATOR DATE

DHEC USE ONLY [ ] APPROVED [ ] NOT APPROVED

_____ _____

AUTHORIZED DHEC SIGNATURE DATE